STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WIN			03/30/	2012
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	ŧ.		1400 M	EDICAL PARK DR		
UNIVERS	SITY PARK HEALTI	H AND REHABILITATION CENTE	R		WAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for	r a Recertification and	F00	00	The creation and submission of this	;	
	State Licensure S	Survey.			plan of correction does not		
					constitute an admission by this		
	Survey dates: M	Iarch 26, 27, 28, 29 & 30,			provider of any conclusion set forth		
	2012				in the statement of deficiencies, or		
					of any violation of regulation.		
	Facility number:	000459			This provider respectfully requests		
	Provider number				that the 2567 plan of correction be considered the letter of credible		
	AIM number: 10				allegation and request a post		
	Anvi number. 10	00289700			certification review on or after		
	~				04/29/2012.		
	Survey team:						
	Angela Strass RN	N TC					
	Sue Brooker RD						
	Rick Blain RN						
	Diane Nilson RN	1					
	Census bed type:	•					
	SNF: 4	•					
	SNF/NF: 78						
	Total: 82						
	Census payor typ	ne.					
	Medicare: 7	,					
	Medicaid: 49						
	Other: 26						
	Total: 82						
	Those state for 1:-	ngg are gited in					
	These state finding	_					
	accordance with	410 IAC 16.2.					
	Quality review com	pleted 4/3/12					
	Cathy Emswiller RN						
	,						

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

TITLE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER: 155567	A. BUILDING B. WING	00		ESURVEY LETED 0/2012		
	PROVIDER OR SUPPLIER SITY PARK HEALT	H AND REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
UNIVERS (X4) ID PREFIX TAG	SUMMARY S (EACH DEFICIEN	H AND REHABILITATION CENT TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LISC IDENTIFYING INFORMATION)			LD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155567		(X2) MU A. BUILI B. WING	DING	NSTRUCTION 00	(X3) DATE S COMPLI 03/30/2	ETED	
	ROVIDER OR SUPPLIER	L AND REHABILITATION CENTE		STREET A	DDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	F	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	(X5) COMPLETION DATE
F0157 SS=D	A facility must im resident; consult and if known, no representative or member when the resident which the potential for intervention; a si resident's physic status (i.e., a det or psychosocial sthreatening cond complications); a significantly (i.e., existing form of the consequences, of treatment); or discharge the respecified in §483. The facility must resident and, if k representative or when there is a classing as change in resident and paragraph (b)(1). The facility must update the addresserver in the resident and the res	NE/ROOM, ETC) Immediately inform the with the resident's physician; tify the resident's legal ran interested family Idere is an accident involving the results in injury and has requiring physician gnificant change in the al, mental, or psychosocial terioration in health, mental, status in either life litions or clinical a need to alter treatment a need to discontinue an reatment due to adverse or to commence a new form a decision to transfer or sident from the facility as 3.12(a). also promptly notify the nown, the resident's legal rinterested family member change in room or roommate pecified in §483.15(e)(2); or dent rights under Federal or ulations as specified in					
	Based on recor interview, the fa the physician w to have lab wor	rd review and acility failed to notify when a resident refused rk done, a prothrombin hal normalization ratio,	F015	7	F 157 – Notify of changes It is the practice of this provider to immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an		04/29/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DDIC	00	COMPL	ETED
		155567	A. BUII			03/30/	2012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	8			EDICAL PARK DR		
I INII\/ED	SITV DADK HEAI T	H AND REHABILITATION CENTE	D	l	WAYNE, IN 46825		
UNIVER	SIII FARRIILALI	TTAND REHABILITATION CENTER		FORT			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	for 1 of 47 resid	dents reviewed who			interested family member when		
met the criteria for physician				there is a significant change in the			
	notification. (resident #91)				resident's physical, mental, or		
					psychosocial status.		
	Finding include	es:			What corrective action(s) will be		
					accomplished for those residents	_	
	Review of the	clinical record on			found to have been affected by the	2	
		a.m. for resident #91			alleged deficient practice: Resident 91's physician was notified	1	
					of the resident's refusal and critical		
		vas admitted to the			PT/INR on 2/23/2012. A physician's		
	_	11 with diagnoses			order was obtained to hold the		
	including but no				resident's Coumadin and recheck		
	Encephalitis, S	eizures, Benign			the PT/INR daily until the INR level		
	Hypertension a	and Cardiomyopathy.			was below 2.8.		
	The resident al	so had short term and			No other residents were affected b	у	
	long term mem	ory problems.			this finding.		
		, ·			How other residents having the		
	Review of nurs	ing notes dated			potential to be affected by the		
		a.m. indicated			same deficient practice will be		
		sed to have PT/INR			identified and what corrective		
					action(s) will be taken:		
	``	me/international			Residents with orders for PT/INR		
		o) drawn, became			monitoring have the potential to be	<u> </u>	
	physical, tried t	to bite staff."			affected. A facility wide audit was		
					completed to ensure all residents		
	On 3/28/12 at 1	10:00 a.m. review of			receiving PT/INR levels been		
	Resident #91's	medication			completed and MD notified of		
	administration	record indicated an			results and/or refusals. No other		
	order dated 2/1	0/12 for coumadin (a			resident were affected. The nurse management team will completed		
		7 milligrams per mouth					
		check PT/INR in 1			this audit. What measures will be put into		
	week.				place or what systemic changes wi	II	
	WCCK.				be made to ensure that the		
	Thorooro :	further nursing pates			deficient practice does not recur:		
		further nursing notes			A mandatory nursing in-service will		
		esidents refusal until			be conducted. This in-service will		
		on 2/23/12 at 9:00			include review of the facility policy		
	l n m which indi	cated. "No s/s (signs of	1]		

STATEMEN	ENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUC		ONSTRUCTION	(X3) DATE SU	JRVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	л ріш	LDING	00	COMPLE	TED
		155567	B. WIN			03/30/2	012
			b. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	R			EDICAL PARK DR		
LINIIVED:	SITY DADK HEAI T	H AND REHABILITATION CENTE	D		VAYNE, IN 46825		
ONIVEIX		THAND REHABILITATION CENTE		TOKTV			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	symptoms of b	leeding or bruising."			titled, "Change in Condition: When		
					to report to the MD/NP/PA". The		
	On 3/28/12 at	1:30 p.m. interview with			DON/DSD and/or designee will be		
		tor and Director of			responsible for conducting the		
	Nursing indicat	ted the resident had			in-service.		
		/INR blood draw and			How will the corrective action(s)		
					will be monitored to ensure the		
	_	ad not contacted the			deficient practice will not recur i.e.	,	
	physician for n	ew orders.			what quality assurance program		
					will be put into place:		
	Review of the t	-			To ensure ongoing compliance with		
	documentation	dated 2/23/12			this corrective action, the		
	indicated that a	at approximately 4:00			DON/designee will be responsible for completion of a PT/INR audit too		
	p.m. the DON	was notified by the unit			· ·	01	
		Resident #9's PT/INR			titled, "Anti-Coagulant Audit Log" daily x 3 weeks, then 3 times a weel	,	
		a critical level with the			for 3 weeks and then weekly	×	
					thereafter. Findings will be		
		resident's physician			submitted to the QA & A committee		
		nd an order was			for review and follow up.		
		d the resident's			By what date the systemic changes	,	
	•	od thinner) and			will be completed: Compliance Date		
	recheck the PT	/INR daily until the INR			= 04/29/2012		
	level was below	w 2.8.			Addendum Request: Finding	ıs	
					will be submitted to the QA &		
	On 3/29/12 at	1:00 p.m. review of the			committee for review and		
		Change in Condition:			follow up times 6 months wit	th	
	, , ,	to the MD/NP/PA"			a subsequent plan develope	d	
					and implemented as necessa	ary.	
	(Medical Docto						
		ysicians Assistant)					
		port immediately any					
		oR involving a					
	cardiac, psycho	otropic, or other drug					
	with potential for	or significant toxic side					
	effects."	-					
	3.1-5(a)(2)						
	3.1-5(a)(3)						

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

If continuation sheet

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (IDENTIFICATION NUMBER: 155567		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION OO	COM	(X3) DATE SURVEY COMPLETED 03/30/2012	
	ROVIDER OR SUPPLIE	R TH AND REHABILITATION CENT	1400 M	ADDRESS, CITY, STATE, ZIP CO EDICAL PARK DR WAYNE, IN 46825	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PERCEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	CTION ULD BE PROPRIATE	(X5) COMPLETION DATE

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		ſ ′) /	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	
		155567	B. WIN	G		03/30/	2012
NAME OF F	PROVIDER OR SUPPLIE	R		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
	no vibilit on bol i bib				EDICAL PARK DR		
UNIVERS	SITY PARK HEALT	TH AND REHABILITATION CENTE	R	FORT V	WAYNE, IN 46825		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
F0282 SS=D	CARE PLAN The services profacility must be in accordance where	QUALIFIED PERSONS/PER ovided or arranged by the provided by qualified persons vith each resident's written					
	plan of care.		F02	82	F 202 Combon by modified		04/29/2012
		ervation, interview and	1.02	02	F 282 – Services by qualified persons/per care plan.		07/27/2012
		the facility failed to			It is the practice of this provider tha	+	
		nn's orders for fluid			services provided or arranged by the		
		1 of 1 resident reviewed			facility must be provided by		
		riteria for dialysis			qualified persons in accordance witl	า	
	(Resident #12	5).			each resident's written plan of care.		
					What corrective action(s) will be		
	Findings include	de:			accomplished for those residents		
					found to have been affected by the	!	
					deficient practice:		
	Review of the	clinical record of			The resident's fluid restriction order	•	
	Resident #125	5 on 3/28/12 at 10:14			was clarified by the physician to 1500cc per day. The current		
	a.m., indicated	the following:			physician order reads dietary to give	2	
		uded, but were not			720 cc and nursing to give 780 cc	-	
		ertension, acute renal			which equals 1500 cc per day.		
		(gastroesophageal			How other residents having the		
), history of pulmonary			potential to be affected by the		
	·	d multiple myeloma.			same deficient practice will be		
		a manapie my diema.			identified and what corrective		
	Δ nhveician's (order for Resident #125,			action(s) will be taken:		
	' *	nonth of March, 2012,			Residents with a current fluid		
		odialysis three times a			restriction physician order have the		
		-			potential to be affected by this		
		day, Wednesday, and			finding. A facility wide audit will be conducted to identify other		
		monitor for signs and			residents with fluid restriction		
	' '	luid overload. The			physician orders to ensure total		
	1	der also indicated a			values match the physician order.		
	· '	c centimeters) fluid			The nurse management team will be	e	
		n dietary to give 720 cc	1		responsible for completing this		
	daily and nurs	ing to give 330 cc on			audit.		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURV			RVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DI 111	LDING	00	COMPLET	ED
		155567	A. BUII B. WIN			03/30/20)12
			B. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIE	₹			EDICAL PARK DR		
LINIVED	CITY DADK HEALT	LI AND BEHABII ITATION CENTE	D		NAYNE, IN 46825		
UNIVER	SIIT FARK HEALT	H AND REHABILITATION CENTE	.Γ.	FORT	WATNE, IN 40825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE C	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	the 7a-3p shift, 330 cc on the 3p-11p				What measures will be put into		
shift, and 120 cc on the 11p-7a shift.				place or what systemic changes wil	ı		
		,			be made to ensure that the		
	A physician tel	ephone order for			deficient practice does not recur:		
		•			A mandatory nursing in-service will		
		, dated 3/13/12,			be conducted. This in-service will		
		00 ml (milliliter) fluid			include review of following		
		ary to give 720 ml			physicians orders and the facility		
	daily, nursing t	o give 330 ml on the			policy y for monitoring resident's		
	7a-3p- shift, 33	30 ml on the 3p-11p			intake with fluid restriction. The		
	shift, and 120 r	ml on the 11p-7a- shift.			DON/DSD and/or designee will be		
		the fluid provided by			responsible for conducting the		
		ch nursing shift			in-service.		
	,	•			How will the corrective action(s) be		
		vould receive 1500 cc's			monitored to ensure the deficient		
	instead of the	1200 cc's as ordered.			practice will not recur i.e., what		
					quality assurance program will be		
	The Medication	n Administration			put into place:		
	Record for Res	sident #125, for the			To ensure ongoing compliance with		
	month of Marc	h, 2012, indicated			this corrective action I/O record will		
		ed Resident #125 with			be reviewed by the DON/designee		
		7a-3p shift, 330 cc on			daily x 2 weeks, 3 times a week x 2		
		•			weeks, 1 time a week x 2 weeks and	l	
		ft, and 120 cc on the			then monthly thereafter. Further		
	l '	total of 780 cc's over			more physician orders will be		
		current tray card for			reviewed during the facility		
	Resident #125	, provided by the			Department Manager meeting.		
	Certified Dietai	ry Manager on 3/29/12			Findings will be submitted to the Q		
	at 9:15 a.m., in	dicated Resident #125			& A committee for review and follow	W	
	received a tota	l of 720 cc's of fluid per			up.		
		ry. Combined with the			By what date the systemic changes		
	1 -	m nursing and the 720			will be completed: Compliance Date	9	
		•			= 04/29/2012	_	
		ry, Resident #125			Addendum Request: Finding will be submitted to the QA &		
		l of 1500 cc's total over			committee for review and	K A	
	the period of 2	4 hours.			follow up times 6 months wi	th	
					·		
	A facility care p	olan for Resident #125,			a subsequent plan developed and implemented as necessa		
		ndicated the problem			and implemented as necesso		

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Event ID: WZLI11

Facility ID: 000459

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3)			(X3) DATE S	X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	DING	00	COMPL	ETED	
		155567	A. BUII			03/30/	2012	
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE			
NAME OF P	PROVIDER OR SUPPLIEF	₹						
		LI AND DELIADII ITATION CENTE	n		EDICAL PARK DR			
UNIVERS	SILY PARK HEALT	H AND REHABILITATION CENTE	K	FORT	VAYNE, IN 46825			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
	area of hemodi	ialysis related to acute						
	renal failure an	d infection at the						
	access site and	d subcutaneous access						
		ions to this problem						
	· ·	vere not limited to,						
	· ·							
	,	nday, Wednesday, and						
	,	ordered, and fluid						
	restriction of 12	200 cc in 24 hours.						
	A facility care p	olan for Resident #125,						
	dated 3/9/12, ir	ndicated the problem						
	· ·	for fluid overload						
		e renal failure and						
		rentions to the problem						
	•							
	•	vere not limited to,						
		takes to ensure fluid						
	intake does no	t exceed 1200 cc daily						
	and monitor for	r signs and symptoms						
	of fluid overloa	d.						
	The Director of	Nursing was						
		3/28/12 at 11:15 a.m.						
	_	rview she indicated						
		's fluid restriction was						
	1200 cc's per 2	24 hours.						
	LPN #2 was inf	terviewed on 3/20/12 at						
	10:00 a.m. Du	ring the interview she						
		dent #125 was on a						
	1200 cc fluid re							
	2.1.25(~)(2)							
	3.1-35(g)(2)							

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	00	- COM 03/3	E SURVEY PLETED 0/2012		
		HAND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE		

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: WZLI11

Facility ID: 000459

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED
		155567	B. WING		03/30/2012
NAME OF E	PROVIDER OR SUPPLIE	D	STREET	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF I	ROVIDER OR SOLITEIE	K.	1400 N	MEDICAL PARK DR	
UNIVERS	SITY PARK HEALT	TH AND REHABILITATION CENTE	R FORT	WAYNE, IN 46825	
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	``	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE
F0354 SS=F	483.30(b)	HRS 7 DAYS/WK,			
33-1	FULL-TIME DO	*			
	_	aived under paragraph (c) or			
	. , ,	n, the facility must use the			
		gistered nurse for at least 8			
	consecutive hou	ırs a day, 7 days a week.			
	Except when wa	aived under paragraph (c) or			
	•	on, the facility must designate			
		se to serve as the director of			
	nursing on a full	I time basis.			
	The director of r	nursing may serve as a			
	_	nly when the facility has an			
		ccupancy of 60 or fewer			
	residents.		F0354		04/29/2012
		view and record	F0334	F 354 – Waiver-RN 8 hours 7 days a	04/29/2012
		cility failed to ensure a		week, Full time DON. It is the practice of this provider to	
	•	rse was on duty 8		use the services of a registered	
		9 of 91 days reviewed.		nurse of at least 8 consecutive hour	S
		otential to effect 82 of		a day, 7 days a week.	
		ho resided in the		What corrective action(s) will be	
	building.			accomplished for those residents	
				found to have been affected by the	2
	Finding include	es:		deficient practice: No resident were found to be	
				affected by this alleged deficient	
		lity staffing schedules		practice.	
		10:15 a.m. indicated the		How other residents having the	
	, ,	which did not have a		potential to be affected by the	
	_	rse working in the		same deficient practice will be	
	building for the	e months of January,		identified and what corrective	
	February and I	March, 2012.		action(s) will be taken:	
				All residents have the potential to b	e
	January 22, 20)12		affected by this finding. The facility	
	January 28, 20			has employed a registered nurse to	
	January 29, 20			work Saturday and Sunday to ensur 7 day week coverage.	e
	February 5, 20			, day week coverage.	

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Event ID: WZLI11

Facility ID: 000459

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPLETED
		155567	B. WIN			03/30/2012
			D. WIIN	_	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	ROVIDER OR SUPPLIER	L				
			_		EDICAL PARK DR	
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE	R	FORT	VAYNE, IN 46825	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	BROWING BLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	February 11, 2	n12			What measures will be put into	
	February 12, 2				place or what systemic changes wil	1
	· ·				be made to ensure that the	
	February 18, 2	012			deficient practice does not recur:	
	March 3, 2012				The facility will employ a registered	
	March 11, 2012	2			nurse for 8 consecutive hours a day,	
			1		7 days a week.	
	On 3/30/12 at 1	10:30 a.m. interview			How will the corrective action(s)	
		or of Nursing indicated			will be monitored to ensure the	
		•			deficient practice will not recur i.e.,	
	_	istered Nurse who had			what quality assurance program	'
	, ,	ed. She indicated she			will be put into place:	
	comes in on the	e weekends, but did			To ensure ongoing compliance with	
	not have docur	nentation of the days			this corrective action, the Executive	
	and hours she	was in the building.			Director/designee will review the	
		G			nursing schedule daily to determine	
	3.1-17(b)(3)				= '	
	3.1-17 (b)(3)				facility need of registered nurse for	°
					consecutive hours a day, 7 days a	
					week. Salaried RN managers will sign	
					in and out on daily staffing sheets or weekends.	1
					By what date the systemic changes will be completed: Compliance Date	
					= 04/29/2012	
					Addendum Request: Findings will	
					be submitted to the QA & A	
					committee for review and follow up	,
					times 6 months with a subsequent	
					plan developed and implemented	
			1		as necessary.	
	l		1			

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Event ID: WZLI11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155567	B. WIN			03/30/	2012
			b. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER				IEDICAL PARK DR		
LINII\/EDG	SITY DADK HEALTI	H AND REHABILITATION CENTER					
UNIVERS	DITTARKTICALTI	TAND REHABILITATION CENTER	`	FORT	WAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0363	483.35(c)						
SS=E		RES NEEDS/PREP IN					
	ADVANCE/FOLL						
		et the nutritional needs of					
	residents in acco						
		ietary allowances of the Food ard of the National Research					
		I Academy of Sciences; be					
		ince; and be followed.					
	Based on obse	rvation, interview and	F03	63	F 363 – Menus meet resident needs	;	04/29/2012
	record review, t	the facility failed to			and preparation in advanced and		
	provide a nutrit	ionally adequate meal			followed.		
	to 18 of 19 resi	dents (Residents #74,			It is the practice of this provider tha		
		#7, #39, #85, #26,			menus meet the nutritional needs o	f	
		#41, #73, #107, #34,			residents in accordance with the	•	
		#80) who reside in the			recommended dietary allowances of		
		•			the Food and Nutrition Board of the		
	Memory Care U	JIIIL.			National Research Council, National		
					Academy of Sciences; be prepared in	1	
	Findings includ	e:			advance; and be followed. What corrective action(s) will be		
					accomplished for those residents		
	The menu for the	ne lunch meal on			found to have been affected by the		
	3/29/12 indicate	ed residents on a			deficient practice:		
	Regular Diet re	ceived a 3 ounce			Residents		
	_	tips, one-half cup of			74,64,70,24,7,39,85,26,40,76,17,41,		
	_	es, one-half cup of			73,107,34,95,75, and 80 did not		
		es blend, 1 slice of			experience any negative outcome as	5	
	_	cup of peaches, and			result of this finding.		
	•	cup of peaches, and			How other residents having the		
	beverages.				potential to be affected by the		
					same deficient practice will be		
	_	rvation of the lunch			identified and what corrective		
		2 at 11:15 a.m.,			action(s) will be taken:		
	Residents #74,	#64, #70, #24, #7,			The identified staff member, Nurse		
	#39, #85, #26,	#40, #76, #17, #41,			1, was thoroughly		
	#73, #107, #34	, #95, #75, and #80			in-serviced/re-educated regarding		
		the Memory Care			the use of the therapeutic spread		
		iting for lunch. LPN			sheet that indicates the		
	anning room wa	9 101 10110111. E1 14			recommended portion sizes. The		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DITT	DDIG	00	COMPLET	ГED
		155567	A. BUII			03/30/20	012
			B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	₹					
LINII\/EDG		LI AND DELIADII ITATION CENTEI	n		EDICAL PARK DR		
UNIVERS	SIIT PARK HEALI	H AND REHABILITATION CENTE	Τ.	FURT	WAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	#1 was observ	ed serving plates for			spread sheet is located in a white		
	the residents of	n the Memory Care			binder on the Memory Care Unit.		
	Unit. Instead of	of using the 6 ounce			What measures will be put into		
	ladle, which wa	as provided for the beef			place or what systemic changes wi	ill	
		N #1 was observed to			be made to ensure that the		
	•	which had been			deficient practice does not recur:		
	_	ve the bread, to serve			An all staff in-service will be		
	the beef tips at	•			conducted. The in-service will include review of facility policies		
	•	•			titled, "Portion Sizes" and "Standar	·d	
		e the tongs twice per			Portions". Further more the	u	
		small pieces of the			in-service will include review the		
		s. Based on visual			therapeutic spread sheets and		
		e residents received			proper food service techniques. The	e l	
	approximately	1 ounce of beef tips au			in-service will be conducted by the		
	jus. A standar	d serving size for 3			Dietary Manager and/or designee.		
	ounces of mea	t equals the size of a			How will the corrective action(s)		
	standard deck	of playing cards.			will be monitored to ensure the		
		. , ,			deficient practice will not recur i.e.	.,	
	A white notebo	ook located on the top			what quality assurance program		
		tor contained the daily			will be put into place:		
	_	at serving utensils to			To ensure ongoing compliance with	1	
		od to ensure residents			this corrective action, the Dietary		
					Manager and/or designee will		
		orrect serving size.			conduct an audit that would include		
	_	ervation of the lunch			proper portion sizes, recommended	d	
		2 at 11:15 a.m., the			food temperature, following the		
	white notebool	k was not out and had			therapeutic spread sheet and food		
	not been revie	wed by LPN #1.			storage guidelines. This audit will be conducted daily x 3 weeks, then 3	e	
					times a week for 3 weeks, then one	_	
	LPN #1 was in	terviewed on 3/30/12 at			time a week for 3 weeks and then	1	
	8:56 a.m. Duri	ng the interview he			monthly thereafter. Findings will b	_{oe}	
		ng utensils used to			submitted to the QA & A committee		
		e residents on the			for review and follow up.		
	•	unit was based on			By what date the systemic change	es	
	habit.	and was based on			will be completed: Compliance Dat		
	וומטונ.				= 04/29/2012		
	The Occasion 15	Niction (Manager (ODM)			Addendum Request: Findings will		
	ine Certified L	Dietary Manager (CDM)					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPLETED
		155567	B. WIN			03/30/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF P	PROVIDER OR SUPPLIEF	8			EDICAL PARK DR	
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE	R		VAYNE, IN 46825	
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE
	was interviewe	d on 3/30/12 at 9:36			be submitted to the QA & A	
	a.m. During th	e interview she			committee for review and follow u	p
	indicated the ki	itchen provides the			times 6 months with a subsequent	
	necessary serv	ring utensils required			plan developed and implemented	
	1	n the Memory Care			as necessary.	
		indicated there was a				
		in the Memory Care				
		ained the daily menus				
		ngs utensils were to be				
		ood. She further				
		otebook was to be				
		rence for staff and the				
		the correct serving				
	utensil for the t	peef tips au jus.				
	A current facilit	y policy "Portion				
	Sizes", dated 2	2008 and provided by				
	the CDM on 3/3	30/12 at 11:05 a.m.,				
	indicated "Th	e menu adopted by				
	the facility will i	Ilustrate portion sizes				
		meet the nutritional				
		et forth in the facility's				
		d to meet the most				
		Dietary Reference				
	Intakes)"	,				
	A current facilit	y policy "Standard				
		d 2008 and provided				
		3/30/12 at 11:05 a.m.,				
	1	ortion sizes are written				
		ensure equal portions				
		orovide adequate				
		. Follow portion sizes				
		s directed by the				
	menuStanda	rd portion control				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER: 155567	A. BUILDING B. WING	00	COMP	COMPLETED 03/30/2012	
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	1400	ET ADDRESS, CITY, STATE, ZIP CODE DI MEDICAL PARK DR T WAYNE, IN 46825	•		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPRO DEFICIENCY)	BE	(X5) COMPLETION DATE	
	the nutrients an appropriate am personA diet all timesNutrit must follow ger guidelines such	na Diet Manual diet should provide all nd energy in					

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Event ID: WZLI11

Facility ID: 000459

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	T OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	00	(X3) DATE COMPI 03/30	LETED			
	ROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825						
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE			

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Event ID: WZLI11

Facility ID: 000459

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY COMPLETED	
		155567	B. WIN	G		03/30/	2012
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	STREET ADDRESS, CITY, STATE, ZIP CODE 1400 MEDICAL PARK DR FORT WAYNE, IN 46825				
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0364 SS=E	provides food preconserve nutritive appearance; and attractive, and an utritito 18 of 19 reside #64, #70, #24, #40, #76, #17, #95, #75, and #Memory Care Utrickles in the side at a.m., Residents #7, #39, #85, #41, #73, #107 were seated in dining room was team table padelivered to the kitchen. The state food were place portable dry was team table painted wells until 7 #3 was observed temperatures of the consequence.	eFER TEMP ceives and the facility epared by methods that e value, flavor, and food that is palatable, the proper temperature. rvation, interview and the facility failed to conally adequate meal dents (Residents #74, #7, #39, #85, #26, #41, #73, #107, #34, #80) who reside in the Unit. e: eservation of the on 3/26/12 at 7:00 6 #74, #64, #70, #24, 26, #40, #76, #17, 7, #34, #95, and #80 the Memory Care iting for breakfast. ns of food were e unit from the facility eam table pans of ed into the wells of the arming units. The ns of food remained in e:15 a.m., when LPN	F03	64	F 364 – Nutritive value/Appear platable/Preferred Temperature It is the practice of this provider that each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is platable, attractive, and at the proper temperature. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents 74,64,70,24,7,39,85,26,40,76,17,41,73,107,34,95,75, and 80 did not experience any negative outcome a result of this finding. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The identified staff members,LPN 3 no longer works for the facility and LPN 1 was thoroughly in-serviced/re-educated regarding food temperatures at the point of service and what action should be taken if food is not at the recommended temperature. As well as recording the food temperature	s S	04/29/2012

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIC	00	COMPLET	ED
		155567	A. BUII			03/30/20	012
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIE	₹			EDICAL PARK DR		
LINII\/EDG	SITV DADK HEAI T	H AND REHABILITATION CENTER	5	l	VAYNE, IN 46825		
	- ANNTILALI	THAND REHABIEITATION CENTER	`	TOKT			
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE (COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
	""	d at 102 degrees and			for all 3 meals in the Food		
		registered at 100			Temperature Log and using a food		
	degrees. LPN	#3 was observed to			thermometer provided by the		
	immediately se	erve the scrambled			Dietary Department. What measures will be put into		
	eggs and the c	atmeal. No attempt			place or what systemic changes wi	.	
	was made to c	ontact the kitchen for			be made to ensure that the	"	
	replacement for	ood items at the			deficient practice does not recur:		
	l '	nperature and no			An all staff in-service will be		
		ade to re-heat the food			conducted. The in-service will		
	1	chen area on the			include review of the facility policy		
					titled, "Food Service Temperature		
	1	unit. There were no			Control", recording of food		
		ures recorded for the			temperature for all 3 meals, and		
		on 3/26/12 in the			what action should be taken if food		
	Food Tempera	lture Log.			is not at the recommended		
					temperature. The in-service will be	e	
	2. During an ol	oservation of the lunch			conducted by the Dietary Manager		
	meal on 3/29/1	2 at 11:00 a.m.,			and/or designee.		
	Residents #74	, #64, #70, #24, #7,			How will the corrective action(s)		
	#39, #85, #26,	#40, #76, #17, #41,			will be monitored to ensure the		
		l, #95, and #80 were			deficient practice will not recur i.e.	,	
		Memory Care dining			what quality assurance program		
		or lunch. Steam table			will be put into place: To ensure ongoing compliance with	.	
		ad just been delivered			this corrective action, the Dietary	·	
	l '	the facility kitchen.			Manager and/or designee will		
		•			conduct an audit that would include	e	
		le pans of food were			proper portion sizes, recommended		
	l •	wells of the portable			food temperature, following the		
	, , ,	nits at 11:12 a.m. by			therapeutic spread sheet and food		
		#1 was observed to			storage guidelines. This audit will be	e	
	•	the temperatures of			conducted daily x 3 weeks, then 3		
	the hot food wi	<u> </u>			times a week for 3 weeks, then one		
	thermometer d	esigned for use on			time a week for 3 weeks and then		
	humans. After	realizing the			monthly thereafter. Findings will b		
	thermometer w	ould not be able to			submitted to the QA & A committee	e	
	read the high to	emperatures of hot			for review and follow up.		
	l –	the thermometer clean			By what date the systemic change	s	
	l		1				

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/02/2012 FORM APPROVED OMB NO. 0938-0391

	IT OF DEFICIENCIES OF CORRECTION	XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567		LDING	NSTRUCTION 00	(X3) DATE : COMPL 03/30/	ETED
	PROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	R	1400 MI	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825	•	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	cart. Provided thermometer by Memory Care to observed to take the hot food at the Food Templunch meal on a following: beef degrees, butter degrees, and the vegetables - 16 were no food to for the alternate chicken breasts the lunch meal. During the observed to he appropriate plugged in during the steam the steam the steam the steam the steam the steam that t	y another staff on the unit, LPN #1 was see the temperatures of 11:15 a.m. Review of perature Log for the 3/29/12 indicated the tip au jus - 176 red noodles - 172 red Italian blend 60 degrees. There remperatures recorded re food choices of s and seasoned rice for			will be completed: Compliance Da = 04/29/2012 Addendum Request: Findings will be submitted to the QA & A committee for review and follow times 6 months with a subsequer plan developed and implemented as necessary.	Jp t	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ RIII	LDING	00	COMPL	ETED
		155567	B. WIN			03/30/	2012
		<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	₹			EDICAL PARK DR		
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE	:R		VAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	indicated he wa	as not sure what to do					
	if the temperate	ures of the hot food					
	were low. He a	also indicated the dry					
	portable warmi	ng units should have					
	been plugged i	in.					
	The Certified D	Dietary Manager (CDM)					
		ed on 3/30/12 at 9:36					
		e interview she					
	_	for the Memory Care					
		red and dished into					
		ins in the facility					
		eratures of the food					
		d then the food was					
	•	the unit. She also					
	· ·	ble dry warming units					
		ne unit to keep the					
		ins of food at the					
		nperature and were to					
		during the meal service.					
		icated temperatures of					
		to be taken before the					
		ed to the residents. A					
		eter was kept in the					
	· ·	unit kitchen area and					
		es were to be recorded					
	in the Food Te	mperature Log. She					
	also indicated t	the facility kitchen was					
	to be contacted	d if the food was not at					
	the appropriate	e temperature at the					
	time of service	•					
	Facility direction	ons for "Taking Food					
		', dated 3/24/10 and					
		Food Temperature Log					
		- F					

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	IT OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING			(X3) DATE SURVEY COMPLETED 03/30/2012	
	PROVIDER OR SUPPLIER	L : H AND REHABILITATION CENTER		STREET A	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825	·	
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	· ·	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION DATE
170	on the Memory but were not lin temperature meach meal, tem must be 160 de service, check the thermomete each hot food of temperature or temperatures be person. A facility policy Temperature Coand provided be at 11:05 a.m., in calibrated food final temperature to and cold, person food not meeting temperature results.	Care unit, included, nited to, food ust be checked with operatures of hot food egrees at the time of food temperature with er provided, check dish and record of log, and check dish effore serving first. "Food Service control", dated 2008 by the CDM on 3/30/12 ondicated "Using a thermometer, obtain res for all menu items, rior to servingAny ong minimum quirements will be coroper temperature		.Au			

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CO		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155567	B. WING		03/30/2012	
NAME OF P	PROVIDER OR SUPPLIEF			ADDRESS, CITY, STATE, ZIP CODE		
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE		IEDICAL PARK DR WAYNE, IN 46825		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	1	CY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION	
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	

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Event ID: WZLI11

Facility ID: 000459

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			A. BUILDING 00 CO			DATE SURVEY COMPLETED	
		155567	B. WIN			03/30/	2012
	PROVIDER OR SUPPLIE	R TH AND REHABILITATION CENTE	R	1400 M	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR NAYNE, IN 46825		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0371 SS=A	483.35(i) FOOD PROCUL STORE/PREPA The facility mus (1) Procure food considered satis local authorities (2) Store, prepa under sanitary of Based on obse review of facilit facility failed to refrigerators. Finding include During the en 3/28/12 at 2:10 the refrigerator care unit indices refrigerator we with clear wra Interview with person indica been left over On 3/30/12 at the facility po undated, indice	RE, ARE/SERVE - SANITARY t - d from sources approved or sfactory by Federal, State or ; and are, distribute and serve food conditions ervation, interview and ty documents the o date food in 1 of 4	F03		F - 371 Food procure, store/prepare/serve - Sanitary It is the practice of this provider tha procures food from sources approved or considered satisfactory by Federal, State or local authorities and store, prepare, distribute and serve food under sanitary conditions. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: No residents were found to be affected by this alleged deficient practice. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken: The identified staff member will be in-serviced/re-educated to facility policy related to labeled and dated food. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur: An all staff mandatory in-service will	i I	04/29/2012
					be conducted. The in-service will		

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	OF CORRECTION	IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CC A. BUILDING	00 	COMPLETED 03/30/2012
		133307	B. WING		03/30/2012
	ROVIDER OR SUPPLIER	H AND REHABILITATION CENTER	1400 M	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	COMPLETION COMPLETION
IAU	REGULATORY OR	LSC IDENTIFYING INFURMATION)	IAG	include review of the facility polititled, "Left Overs". How will the corrective action(s) will be monitored to ensure the deficient practice will not recur what quality assurance program will be put into place: To ensure ongoing compliance withis corrective action, the Dietary Manager and/or designee will conduct an audit that would inclust proper portion sizes, recomment food temperature, following the therapeutic spread sheet and foostorage guidelines. This audit will conducted daily x 3 weeks, then times a week for 3 weeks, then times a week for 3 weeks, and the monthly thereafter. Findings will submitted to the QA & A committed for review and follow up. By what date the systemic chant will be completed: Compliance Compl	ith ith ude ded ded be 3 ne n II be tee ges cate II v up ent

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED	
		155567	B. WING		03/30/2012
	ROVIDER OR SUPPLIER	H AND REHABILITATION CENTE	1400 M	ADDRESS, CITY, STATE, ZIP CODE IEDICAL PARK DR WAYNE, IN 46825	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
F0441 SS=D	483.65 INFECTION COI SPREAD, LINEN The facility must Infection Control provide a safe, s environment and development and and infection. (a) Infection Con The facility must Control Program (1) Investigates, infections in the (2) Decides what isolation, should resident; and (3) Maintains a re corrective action (b) Preventing S (1) When the Infedetermines that a prevent the spre- must isolate the (2) The facility m communicable d lesions from dire their food, if direct disease. (3) The facility m hands after each	establish and maintain an Program designed to anitary and comfortable to help prevent the ditransmission of disease trol Program establish an Infection under which it - controls, and prevents facility; to procedures, such as be applied to an individual ecord of incidents and sirelated to infections. Pread of Infection ection Control Program a resident needs isolation to ad of infection, the facility resident. Pust prohibit employees with a isease or infected skin ct contact with residents or ct contact will transmit the contact resident contact for hing is indicated by accepted	TAG	DEFICIENCY)	
	(c) Linens Personnel must transport linens s of infection.	handle, store, process and so as to prevent the spread	F0441	F 441 – Infection control,	04/29/2012
		the facility failed to		Prevent Spread, Linens It is t	he

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STATEMENT OF DEFICIENCIES X1) PRO		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIT	LDING	00	COMPLETED	
		155567	A. BUI B. WIN	LDING		03/30/2012	
			B. WIN		ADDRESS CITY STATE ZIR CODE		
NAME OF P	ROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
				EDICAL PARK DR			
UNIVERS	SITY PARK HEALT	H AND REHABILITATION CENTE	:R	FORT	WAYNE, IN 46825		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION	
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	DATE	
	ensure 1 of 4	nurses who were			practice of this provider to		
	observed durin	ng medication			establish and maintain an		
		washed and/or			Infection Control Program		
					designed to provide a safe,		
		hands for 3 of 11			sanitary and comfortable		
		rved during medication			environment and to help preven	ent	
	administration.	(Residents #26, #39			the development and		
	and #40)				transmission of disease and		
					infection.What corrective		
	Finding include	<u> </u>			action(s) will be accomplished	ea	
	i mamg molaac				for those residents found to		
	0= 2/20/42 =+	0.20 a m. abaamiatian			have been affected by the	200	
		8:30 a.m. observation			deficient practice: Residents		
		dicated he was passing			39, 40 did not experience any negative outcome as a result		
	medications to	residents. The nurse			this alleged finding. How other		
	prepared and a	administered			residents having the potentia	l l	
	medications fo	r residents #26, #39			to be affected by the same	"	
	and #40.	,			deficient practice will be		
					identified and what corrective	re l	
	During the ada	ninistration of the			action(s) will be taken: All		
	_				residents have the potential to	be	
		e nurse touched the			affected by this finding. The		
		dministration cups after			identified staff member, Nurse	: 1,	
	the residents h	ad put the cup to their			will be thoroughly		
	mouths. The r	nurse was also			in-serviced/re-educated on pro	oper	
	observed to to	uch the resident's			Medication Administration		
		lchairs, bedside tables			practices and hand washing		
	J .	Nurse #1 did not wash			practices during Medication		
					Administration. What measure		
		only used sanitizer			will be put into place or wha		
		ering the medications to			systemic changes will be ma	iae	
	the 3 residents	5.			to ensure that the deficient		
					practice does not recur: An a	lik	
	On 3/29/12 at 9	9:20 a.m. interview with			nursing staff in-service will be conducted. The in-service will		
	nurse #1 indica	ated he only washes			include review of the facility p		
		ng medication pass if			titled, "Medication Administrat		
	he touches a re	•			and hand washing practices		
	The louches a fi	coluciil.			during Medication Administrat	ion.	
					The DON/DSD and/or designed		
	∩n 3/20/12 at	1:00 n m review of the			1 2 2 3 1 1 2 2 2 4 1 1 4 7 5 1 4 6 6 1 9 1 1		

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CC A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2012
	PROVIDER OR SUPPLIER SITY PARK HEALTH AND REHABILITATION CENTER	STREET A	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR NAYNE, IN 46825	· ·
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	facility policy for "Medication Administration", which was undated, indicated hands were to be washed or use hand sanitizer when touching a resident or assisting a resident to take medications. 3.1-18(I)		will be responsible for conduct the scheduled in-service. How will the corrective action(s) who be monitored to ensure the deficient practice will not recipie., what quality assurance program will be put into place Each nurse will complete a check-off/return demonstration medication administration including hand washing techniques. Any observed concerns noted during check-off will be addressed and corrected immediately. The DON and/or designee will responsible for completion of return demonstration skills check off. Three Medication Administration observations will be completed weekly for one month and ther monthly for four months. Medication Administration observations will be conducted varying shifts. Any findings will reported to QA & A committee review and follow up. By what date the systemic changes who completed: Compliance Down and the completed of the QA & A committee for review and follow up times 6 months with a subsequent plan developed and implemented as necessariant.	vill cur e: n on offs ed on it on it be for t vill ate

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X2) MULTIPLE CONSTRUCTION (X3) DATE			(X3) DATE S	SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING COMPLE					
		155567	B. WING	3		03/30/	/30/2012	
NAME OF PROVIDER OR SUPPLIER UNIVERSITY PARK HEALTH AND REHABILITATION CENTER		₹	1400 MI	NDDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	(EACH DEFICIEN	CY MUST BE PERCEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIATE		COMPLETION	
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE	
F0520 SS=E	483.75(o)(1) QAA COMMITTI QUARTERLY/PI A facility must m and assurance of director of nursir designated by th members of the The quality asse committee meets issues with respirancessessment and necessary; and of	EE-MEMBERS/MEET LANS aintain a quality assessment ommittee consisting of the ag services; a physician e facility; and at least 3 other						
	identified quality A State or the S disclosure of the except insofar as the compliance of requirements of Good faith attern identify and corre not be used as a Based on recon interview, the fa the facility's Qu Assurance (QA identified conce nutritionally add serving food at temperature, a stored in the re memory care u 18 of 19 reside	ecretary may not require records of such committee so such disclosure is related to of such committee with the this section. The pts by the committee to ect quality deficiencies will basis for sanctions. The review and accility failed to ensure relative Assessment and the committee erns regarding serving requate food portions,	F052	20	F 520 – QA&Committee-Members/Me Quarterly/Plans It is the practi of this provider that a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice: Residents 74,	ice	04/29/2012	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETE			ETED		
		155567	A. BUII B. WIN			03/30/2	2012
			b. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER							
UNIVERSITY PARK HEALTH AND REHABILITATION CENTER		₽	1400 MEDICAL PARK DR R FORT WAYNE, IN 46825				
			`		T +0025		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		CROSS-REFERENCED TO THE APPROPRIATE		TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		44	DATE
		#7 , #39 , #85 , #26 ,			64,70,24,7,39,85,26,40,76,17,73,107,34,95,75 and 80 did no		
	#40, #76, #17,				experience any negative outcome		
	#107, #34, #9	5, #75, and #80			as a result of this finding. How		
					other residents having the		
	Finding include	es:			potential to be affected by th	e	
					same deficient practice will b		
	The facility's E	xecutive Director (ED)			identified and what correctiv	e	
	,	d on 3/30/2012 at			action(s) will be taken:		
		iring the interview, the			Residents residing on the		
		ne facility had a QAA			Memory Care have the potent	ial	
		•			to be affected by this alleged	_	
		met quarterly to			finding.What measures will b		
	_	rrect quality concerns.			put into place or what syster changes will be made to	IIIC	
	_	rview, the ED indicated			ensure that the deficient		
		ot identified any			practice does not recur: An a	all	
	concerns on th	e memory care unit			staff in-service will be conduct		
	regarding food	service and food			The in-service will include the		
	storage on the	memory care unit.			facility policies titled, "Left-Ove	ers",	
	-				"Food Temperature Control",		
	A facility policy	titled "Quality			"Portion Sizes", and "Standard	j	
		Program", dated			Portions". In addition, the	:4	
	_	indicated "it is a policy			in-service will include the facili practice as it related to the din	,	
	•	al Quality Management			service on the Memory Care U	-	
		intained to monitor and			The in-service will be conducted		
	_	uality of resident care			by the Dietary Manager/design		
	=	_			How will the corrective		
	•	ue methods to improve			action(s) will be monitored to		
		areas of organizational			ensure the deficient practice		
	_	d to promote safety by			will not recur i.e., what qualit	-	
	using a system	•			assurance program will be p		
	identification a	nd resolution process.			into place: To ensure ongoing compliance with this corrective		
					action, the Executive	-	
	See F 363 rega	arding: Based on			Director/designee will complet	ea I	
	observation, in	terview and record			QA&A audit titled, "Memory C		
	review, the fac	ility failed to provide a			Center Review". The Audit wil		
		equate meal to 18 of			completed monthly and results		
	_	Residents #74, #64,			will be reviewed by the QA&A		

	NT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155567	(X2) MULTIPLE CO A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 03/30/2012
	PROVIDER OR SUPPLIER SITY PARK HEALTH AND REHABILITATION CENTER	1400 MI	ADDRESS, CITY, STATE, ZIP CODE EDICAL PARK DR VAYNE, IN 46825	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	#70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. See F 364 regarding: Based on observation, interview and record review, the facility failed to provide a nutritionally adequate meal to 18 of 19 residents (Residents #74, #64, #70, #24, #7, #39, #85, #26, #40, #76, #17, #41, #73, #107, #34, #95, #75, and #80) who reside in the Memory Care Unit. See F 371 regarding: Based on observation, interview and review of facility documents the facility failed to date food in 1 of 4 refrigerators. 3.1-52(b)(1)		committee with actions plans developed as needed. By whate the systemic changes were completed: Compliance Day 2012Addendum Request: Findings will be submitted to the QA & A committee for review and follow up times 6 months wire a subsequent plan developed and implemented as necessary	vill ate th

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